STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155785			A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 05/04/2012	
	PROVIDER OR SUPPLIE		714 8	T ADDRESS, CITY, STATE, ZIP CODE S EICKHOFF RD NSVILLE, IN 47712		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
F0000	Complaint IN00 Federal/State de allegations are of Survey dates: May 3 and 4, 20 Facility number Provider number AIM number: 2 Survey team: Anne Marie Crate Census bed type SNF: 40 SNF/NF: 5 Residential: 57 Total: 102 Census payor ty Medicare: 26 Medicaid: 5 Other: 71 Total: 102 Sample: 7	2107337- Substantiated, efficiencies related to the eited at F314 and F514.  212  213  21448  2155785  201039500  2298, R.N.	F0000	Preparation or execution of the plan of correction does not constitute admission or agreement by the provider of truth of the facts alleged, or conclusions set forth on the statement of deficiencies.  This plan of correction is prepared and executed solely because it is required by Fed and State law.  This plan of correction is submitted in order to respond the allegations of noncomplia cited during compliant survey review concluding on 5-4-201  Please accept this plan of correction as the provider's credible aggregation of compliance effective on or be 6-1-2012  We respectfully request a degree for compliance.	the  / eral  I to nce 2	

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

T6UX11

Facility ID:

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155785			00		LETED 1/2012			
	PROVIDER OR SUPPLIER	PUS	B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  714 S EICKHOFF RD  EVANSVILLE, IN 47712						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			
		s reflect state findings ce with 410 IAC 16.2.							
	Quality review co	ompleted on May 8, 2012 RN							

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Event ID: T6UX11

Facility ID: 012448

If continuation sheet

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155785	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 05/04/2012	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 714 S EICKHOFF RD EVANSVILLE, IN 47712				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0314 SS=G	PRESSURE SOI Based on the col a resident, the faresident who ent pressure sores of sores unless the demonstrates that and a resident have receives necessare promote healing, prevent new sore Based on intervite facility failed to for pressure ulce. Stage IV pressure residents reviewed in a sample of 7.  Findings include  1. The closed clin G was reviewed The resident was on 11/21/11 with not limited to, An and Psychosis.	mprehensive assessment of cility must ensure that a ers the facility without oes not develop pressure individual's clinical condition at they were unavoidable; aving pressure sores ary treatment and services to prevent infection and es from developing.  ew and record review, the ensure a resident at risk are did not develop a e ulcer, for 1 of 3 ed with pressure ulcers, Resident G  :  mical record of Resident on 5/3/12 at 11:25 A.M. admitted to the facility diagnoses including, but memia, Hypothyroidism,	F03	14	F 314  Resident G no longer resides in the health campus  Completion Date 6-1-2012  All residents have the potential be affected by the alleged deficient practice and through altercations in processes and is servicing the campus will ensure measures to prevent the development of new pressure sores and provide care for curpressure ulcers in accordance with physician's orders  Completion Date 6-1-2012	I to in ire rent	06/01/2012
	undated, indicate assistance with to dressing, and toil assessment indic fairDoes the re	eting. The skin			All licensed staff have been in serviced on 1. completion of admission assessments concerning the sportion 2. A thorough full body skin assessment and documentation of assessment		

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Event ID: T6UX11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC	00	COMPLETED
		155785	A. BUII B. WIN			05/04/2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R			EICKHOFF RD	
WEST D	IVER HEALTH CAN	ADUS		EVANSVILLE, IN 47712		
	·	WI 03			7 (ILLE, III 4// IZ	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG		DATE
	_	ing pressure ulcer? N.			3.On completion of Skilled Nursing Assessments and Da	ta
	Pressure ulcer k	nown to be present?			Collection	ia
	NSkin is expo	sed to			4. On wound/assessment	
	moisture/inconti	nence? Y [yes]" An			documentation and appropriate	te
	anatomical draw	ring documented an "X"			treatments	
	on the left butto	ck area with the notation				
	"abrasion." A	Skin Plan of Care," which			Completion Data 6.4 0040	
		assessment, indicated:			Completion Date 6-1-2012	
	_	ition for comfort and with			Systemic changes as follows	
	_	ressure relieving device in			Licensed nurses to complete	a
	_	sure resident is clean and			return demonstration of a full	
		positioning in bed and			body skin assessment and	
	1 -	positioning in bed and			documentation of assessment	
	chair."				now and annually thereafter. A treatment options protocol has	
					been placed in all Treatment	·
		ta Set [MDS] assessment,			Binders as a guidance for nur	ses.
	dated 11/28/11,	indicated the resident had				
	no memory prob	olems, and required				
	extensive assista	ance of one staff for bed			Completion Date 6-1-2012	
	mobility, transfe	er, and toilet use. The			DHS or designee will perform	
	MDS assessmen	t indicated the resident			audits on 3 random residents	to
	was occasionally	y incontinent of bowels			assure complete and accurate	
	_	s at risk of developing			documentation of new	
		and did not have a			wounds/existing wounds,	
	pressure ulcer at				treatment orders obtained time	·
	pressure uteet at	time tillie.			and accurate assessments or skilled sheets 5x a week x one	
	A Cara Dlan das	ted 12/8/11, indicated			month 3x a week x one month	
	•	· · · · · · · · · · · · · · · · · · ·			then weekly with results	
		teration in skin integrity			forwarded to the QA committee	ee
	1	Immobility, Incontinence,			monthly x 6 months and quart	
	-	condition: DDD,			thereafter for review and furth	er
		thritis, Anemia." The			suggestions/comments.  Completion Date 6-1-2012	
		cluded: "Assess/record			Completion Date 6-1-2012	
	changes in skin	status. Report pertinent				
	changes in skin	status to physicianTurn				
	and reposition e	very two				

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Event ID: T6UX11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155785		LDING	NSTRUCTION 00	(X3) DATE COMPL 05/04	ETED	
	PROVIDER OR SUPPLIER		 714 S E	DDRESS, CITY, STATE, ZIP CODE ICKHOFF RD VILLE, IN 47712	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	hoursMinimize [sic] prominence	e pressure over boney s"				
	12/11/11 at 12:30 "Abraised area n	g Assessment, dated O P.M., indicated, oted left buttocks. [Name cified. New orders				
	12/11/11, indicat IdentificationP	resent on admission? Y, Location: Left, Length				
	indicated, "Calaz	der, dated 12/11/11, cyme to abrasion Left y] shift x 14 days."				
	12/12/11, 12/13/ 12/16/11, and 12	Assessments, dated 11, 12/14/11, 12/15/11, /17/11 each indicated, kin impairment: N				
	P.M., indicated, [treatment] order	dated 12/17/11 at 1:30 "Rec. [received] new tx rs from [name of TO [telephone order] this				
	indicated, "1. D/0	der, dated 12/17/11, C [discontinue] aised area left buttock. 2.				

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLE	ETED
		155785	B. WIN			05/04/2	2012
NAME OF B	DROVIDED OD GLIDDLIEF			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	C		714 S E	ICKHOFF RD		
	IVER HEALTH CAN				VILLE, IN 47712		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	ì ·	CH DEFICIENCY MUST BE PERCEDED BY FULL  LATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		·	-	TAG	DLI ICILIACI )	1	DATE
		ft buttock [with] N/S					
		Apply Optifoam AG					
	[change] Q 3rd d	lay."					
		regarding the appearance					
		lcer on 12/17/11 or the					
		w treatment order was					
	lacking in the cli	nical record.					
		ated 12/19/11 at 3:00					
	P.M., indicated,	"Res [resident] has a					
	wound [left] but	tock - area is 4.3 length 4					
	cm [centimeters]	width. Area is necrotic -					
	stage IV - Optifo	oam AG applied - New					
	orders for Zinc 2	20 mg daily x 1 mo and					
	Vitamin C 500 n	ng x 1 mo Culture					
		tock - cushion for w/c					
	[wheelchair]."						
	[ [						
	A "PressureUle	cer Assessment,"					
	indicated, "Initia	l Identification, Date:					
		nt on admission? Y,					
		uttock, Stage/Thickness:					
	E ["E:	, ,					
	_	slough/eschar"]Exudat					
	e: S [serous], Co	_					
		inding tissue: red"					
		<i>5</i>					
	A Physician's Pr	ogress Note, dated					
	1	ted: "Patient does have					
		d with necrotic base to the					
	coccyx"	d with heerone base to the					
	coccyx						
	A Pressure Ulcer	r Assessment then					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155785		LDING	00	05/04/	
		100700	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/01/	2012
NAME OF F	PROVIDER OR SUPPLIER				ICKHOFF RD		
	IVER HEALTH CAM				VILLE, IN 47712		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
1110	included the follo	,		1110			5.112
	12/27/11: "Press	•					
	· ·	cm) L [length] 4.3, W					
	_	oth] <0.1Wound					
		e type/percent/location:					
	_ <del></del>	nd black]Surrounding					
	tissue: R [red]						
	   1/2/12: "Pressure	e/stage: II, Measurements,					
	L 7.3, W 5.3, D						
	BedColorY/I						
		Surrounding tissue: R					
	[red]"	-					
	A Physician's Pro	ogress Note, dated					
	1/6/12, indicated	, "Decubitus Ulcer,					
	buttock, Patient l	pasically has					
		e IV ulcer in the sacral					
		ecently debrided by					
		nk she needs wound VAC					
		cal consultation at this					
		nd her to the hospital for					
	same"						
	On 5/3/12 at 3:4	5 P.M., during interview					
		at Director of Nursing					
		I # 1, they each indicated					
		Resident G's buttocks					
	•	or on 12/11/11, so they					
	_	at the abrasion looked					
	_	e wasn't a treatment order					
		ADON indicated, "We					
		ed at the progression of					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155785		A. BUI	LDING	NSTRUCTION  00	(X3) DATE COMPI 05/04	ETED	
NAME OF I	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
WEST R	IVER HEALTH CAN	1PUS		EVANS	VILLE, IN 47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
	the wound" from The ADON indices were checking the checked "no skir RN # 1 indicated December 2011, measurements we initial identificated did not respond to the documentation when the pressur yellow tissue. The indicated they did nurse obtained a 12/17/11, but the documentation of 12/19/11.  On 5/3/12 at 4:2: with RN # 2, she nurse who perform assessment of Re RN # 2 indicated remember," but it marked as an abit "probably redder breakdown." RN not think it would area.  2. On 5/4/12 at 1 Administrator processing the checked in	a 12/11/11 until 12/19/11.  cated the nurses probably the pressure area, but just a impairment" as routine. If she had just started in but had done the wound eekly following the ion on 12/19/11. RN # 1 when queried regarding on of "Stage II" areas, the ulcers had black and the ADON and RN # 1 If d not know why the treatment order on the was not If the pressure ulcer until  S. P.M., during interview indicated she was the thread the initial tesident G on 11/21/11. If she "really didn't indicated the area she that are					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155785		A. BUILDING  B. WING			COMPLETED 05/04/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				EICKHOFF RD		
	IVER HEALTH CAM	IPUS			VILLE, IN 47712		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG				TAG	BEIGHACT		DATE
		Wound Condition Report					
	•	ated. The Pressure					
		y included: "Purpose: To					
		in integrity and avoid					
	development of p						
		plan interventions shall					
	•	based on risk factors					
		nursing assessment.					
		y include but not be					
	•	ect the skin daily during					
	_	breakdown or changes to					
	-	range of motion] with					
	-	of daily living], if					
		ish an individualized					
	_	if resident is immobile					
	-	Frequency of position					
	_	ualizedObtain an					
	•	re reduction cushion for					
		The Pressure/Stasis					
		n Report policy included:					
		m when an area of					
	impairment, (e.g.						
	rashabrasion)						
	Complete the sec						
		its entirety5. Document					
	_	ound6. Document					
	objective informa	ation about pain"					
	At that same time	e, the Administrator					
		ent facility policy on					
	-	ssessment Guideline,"					
		e policy included: "In					
		eekly Assessment by the					
		e nursing assistant shall					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	00	COMPL	
		155785	B. WING			05/04/	2012
NAME OF I	PROVIDER OR SUPPLIE	R	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ICKHOFF RD		
WEST R	IVER HEALTH CA	MPUS		EVANS'	VILLE, IN 47712		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		for areas of impairment					
	_	d daily dressing and					
	-	tify the nurse if an area is					
	identified.".						
	2   Stages = £D	aggura III aggura II. A MID A					
	_	essure Ulcers," AMDA -					
	•	he following: Stages of					
		: Stage I: Intact skin with					
		redness of a localized area,					
	_	ony prominence. Darkly					
		may not have visible					
	J	its color may differ from					
	_	area. Note: This area					
		firm, soft, warmer or					
	_	d to adjacent skin. Stage					
		ness loss of dermis					
		shallow open ulcer with a					
	-	ed without slough. May					
	-	an intact or open/ruptured					
		ster. Note: This stage					
		sed to describe skin tears,					
	tape burns, perii						
		xcoriation. Stage III: Full					
		loss. Subcutaneous fat					
	_	out bone, tendon or muscle					
	_	Slough may be present					
		scure the depth of tissue					
	loss. May inclu	de undermining and					
	tunneling. Stage	e IV: Full thickness tissue					
	loss with expose	ed bone, tendon, or					
	muscle. Slough	or eschar may be present					
	on some parts o	f the ulcer bed. Often					
	includes undern	nining and tunneling.					
	Note: The dept	h of a Stage III or IV					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155785		(X2) MULTIP  A. BUILDING  B. WING		00	(X3) DATE SURVEY  COMPLETED  05/04/2012			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 714 S EICKHOFF RD EVANSVILLE, IN 47712					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
	of the nose, ear,	cical location. The bridge occiput and malleolus do neous tissue and these llow.						
	This federal tag I IN00107337.	relates to Complaint						
	3.1-40(a)(1)							

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Event ID: T6UX11

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING	00	COMPL	ETED
		155785	A. BUILDING B. WING			05/04/2012	
			b. Why		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			EICKHOFF RD		
WEST RI	IVER HEALTH CAM	1PUS			VILLE, IN 47712		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0514	483.75(I)(1)						
SS=D	RES						
		MPLETE/ACCURATE/ACCE					
	SSIBLE						
		maintain clinical records on					
		accordance with accepted ndards and practices that are					
		ately documented; readily					
		systematically organized.					
		oyetea.ioay o.ga=oa.					
	The clinical reco	rd must contain sufficient					
		entify the resident; a record					
		assessments; the plan of					
		s provided; the results of any					
	•	reening conducted by the					
	State; and progre		F0.5	1.4			06/01/2012
		ation, interview, and	F05	14	F 514		06/01/2012
	record review, th	e facility failed to ensure			Res F has had a full body skir	n	
	documentation w	vas accurate regarding			assessment and al impairment		
	pressure ulcers: i	in that, skilled nursing			have been documented. Resid		
	assessments indi	cated "no areas of skin			G no longer lives in this campu	us	
		he presence of skin					
	impairment; and	_			Completion Date 6-1-2012		
		ment, document a			<b></b>		
		,			All residents have the potentia	ı to	
	•	hen initially found,			be affected by the alleged deficient practice and through		
	, ,	ressure areas, and			alterations in processes and in	1	
	correctly indicate	e a pressure area was			servicing will ensure the camp		
	developed in the	facility, for 2 of 3			must maintain clinical records		
	residents reviewe	ed for pressure areas, in a			each resident in accordance w	vith	
	sample of 7. Res	•			accepted professional standar		
	1 1 7 7 20	<del></del>			and practices that are complet		
	Findings include				;accurately documented; readi		
	i mamga merude				accessible; and systematically	'	
	1 0 . 5/2/12 + 0				organized. Completion Date 6-1-2012		
		:45 A.M., during the			Completion Date 0-1-2012		
	· ·	<sup>‡</sup> 1 indicated Resident F					
	had a Stage II pro	essure area to her left			All licensed staff have been in		
	buttock, coccyx	area.			serviced on		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLE	ETED
		155785	B. WIN			05/04/2	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					EICKHOFF RD		
WEST RIVER HEALTH CAMPUS			EVANSVILLE, IN 47712				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	<b> </b> `			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ΓE	COMPLETION
TAG							DATE
	reviewed on 5/3/ Minimum Data S dated 4/9/12, ind one Stage II pres A PressureUlc dated 4/8/12, ind	er Assessment, initially licated: "Location: 4/23/12: Pressure/stage:			completion of admission assessments concerning the sportion     A thorough full body skin assessment and documentation of assessment     Completion of Skilled Nursing Assessments and Data Collection     On wound/assessment documentation and appropriate treatments	on a	
	Skilled Nursing Assessment and Data Collection notes, dated 4/29/12, 5/1/12, and 5/3/12, indicated: "History of resolved ulcer(s): N [no]Currently has skin impairment? N [no]"				Completion Date 6-1-2012  Systemic changes as follows Licensed nurses to complete a return demonstration of a full	1	
					body skin assessment and documentation of assessment now and annually thereafter. A	١	
	On 5/3/12 at 2:0	0 P.M., a skin assessment			treatment options protocol has been placed in all Treatment	•	
	was requested. A	A pressure area on			Binders as a guidance for nurs	ses.	
		buttocks was observed to					
	be open, with a pink wound bed, and redness to the bilateral inner buttocks.				Completion Date 6-1-2012		
	with the Assistar [ADON] and RN indicated she tho assessing the pre checking no skin	bught the nurses were essure area, but were "just a impairment as routine."			DHS or designee will perform audits on 3 random residents assure complete and accurate documentation of new wounds/existing wounds, treatment orders obtained time and accurate assessments on skilled sheets 5x a week x one month 3x a week x one month then weekly with results	ely,	
		nical record of Resident on 5/3/12 at 11:25 A.M.			forwarded to the QA committee		
					monthly x 6 months and quarte thereafter for review and further		
The resident was admitted to the facility				I mereanter for review and fulfill	51 E		

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Event ID: T6UX11

Facility ID: 012448

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155785		A. BUI	LDING	00	COMPLI 05/04/2		
		155785	B. WIN			03/04/	2012
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
MEST DIVED LIENT THE CAMPLIS			714 S EICKHOFF RD EVANSVILLE, IN 47712				
	WEST RIVER HEALTH CAMPUS			<u> </u>	VILLE, IN 47712	ı	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
1110		diagnoses including, but		1110	suggestions/comments.  Completion Date 6-1-2012		BITTE
		nemia, Hypothyroidism,					
	and Psychosis.	nema, Trypouryroidism,					
	and r sychosis.						
	A Nursing Admi	ssion Assessment,					
		the clinical record. The					
	· · · · · · · · · · · · · · · · · · ·	indicated: "Turgor					
		sident have a Stage I					
		? N [no]Is resident at					
		ng pressure ulcer? N.					
		nown to be present?					
	NSkin is expos						
	_	nence? Y [yes]" An					
		ing documented an "X"					
		· ·					
	on the left buttock area with the notation "abrasion."						
	aurasiuii.						
	A Minimum Dat	a Set [MDS] assessment,					
		ndicated the resident did					
		are ulcer at that time.					
	not have a presst	are theer at that time.					
	Δ Skilled Nursin	g Assessment, dated					
		0 P.M., indicated,					
		oted left buttocks. [Name					
		tified. New orders					
	received"	ined. New Orders					
	10001vod						
	Δ Skin Impairma	ent Assessment, dated					
	12/11/11, indicat	•					
	· ·	resent on admission? Y					
		asion, Location: Left,					
		th 0.4, Depth <.1"					
	Lengui 0.4, w 10	ııı v.+, D€µııı >.1					
	A Physician's ord	der, dated 12/11/11,					

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Event ID: T6UX11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155785		(X2) MULTIPLE CO  A. BUILDING  B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 05/04/2012	
NAME OF PROVIDER OR SUPPLIER WEST RIVER HEALTH CAMPUS		714 S E	ADDRESS, CITY, STATE, ZIP CODE EICKHOFF RD VILLE, IN 47712		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	-	zyme to abrasion Left ry] shift x 14 days."			
	12/12/11, 12/13/ 12/16/11, and 12	Assessments, dated /11, 12/14/11, 12/15/11, 2/17/11 each indicated, kin impairment: N			
	A Nursing Note, dated 12/17/11 at 1:30 P.M., indicated, "Rec. [received] new tx [treatment] orders from [name of physician]. See TO [telephone order] this date."				
	indicated, "1. D/ Calazyme to abr Cleanse area Le	raised area left buttock. 2.  ft buttock [with] N/S  Apply Optifoam AG			
	of the pressure u	regarding the appearance alcer on 12/17/11 or the ew treatment order was inical record.			
	P.M., indicated, wound [left] but cm [centimeters stage IV - Optife orders for Zinc 2	ated 12/19/11 at 3:00 "Res [resident] has a tock - area is 4.3 length 4 ] width. Area is necrotic - oam AG applied - New 220 mg daily x 1 mo and mg x 1 mo Culture			

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	OF CORRECTION  OF CORRECTION  155785	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 05/04/2012			
NAME OF PROVIDER OR SUPPLIER WEST RIVER HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 714 S EICKHOFF RD EVANSVILLE, IN 47712					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION			
	wound [left] buttock - cushion for w/c [wheelchair]."						
	A "PressureUlcer Assessment," indicated, "Initial Identification, Date: 12-19-11, Present on admission? Y, Location [left] buttock, Stage/Thickness: E ["E: Un-stageable]slough/eschar"]Exudat e: S [serous], Color: necroticSurrounding tissue: red"  A Physician's Progress Note, dated 12/22/11, indicated: "Patient does have a stage III wound with necrotic base to the coccyx"  A Pressure Ulcer Assessment then included the following:  12/27/11: "Pressure/Stage: II, Measurements (cm) L [length] 4.3, W [width] 4, D [depth] <0.1Wound BedColor/tissue type/percent/location: Y & B [yellow and black]Surrounding tissue: R [red]"  1/2/12: "Pressure/stage: II, Measurements, L 7.3, W 5.3, D <0.1Wound BedColorY/B [yellow/black]Surrounding tissue: R [red]"  A Physician's Progress Note, dated						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  OO COMPLETED					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. building 00					
		155785	B. WIN			05/04/	2012
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE		
WEST RIVER HEALTH CAMPUS					ICKHOFF RD VILLE, IN 47712		
				l	VILLE, IIV <del>7</del> 7712		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)				ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION
TAG							DATE
	1/6/12. indicated	, "Decubitus Ulcer,					
	buttock, Patient 1						
	·	e IV ulcer in the sacral					
		recently debrided by					
		nk she needs wound VAC					
	and expert surgion	cal consultation at this					
		nd her to the hospital for					
	same"	_					
		5 P.M., during interview					
		nt Director of Nursing					
	1 2	# 1, they each indicated					
	they did not see Resident G's buttocks						
	_	or on $12/11/11$ , so they					
	I	at the abrasion looked					
		e wasn't a treatment order					
		ADON indicated, "We					
		ed at the progression of					
		12/11/11 until 12/19/11.					
		cated the nurses probably					
	_	ne pressure area, but just					
		impairment" as routine.					
		she had just started in					
	· ·	but had done the wound					
		eekly following the					
		ion on 12/19/11. RN # 1					
	_	when queried regarding					
		on of "Stage II" areas,					
	_	re ulcers had black and					
	*	te ADON and RN # 1					
	1	d not know why the treatment order on					
	12/17/11, but the	f the pressure ulcer until					
		i die pressure dicei until					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPL		
		155785	B. WINC			05/04/	2012
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
			714 S EICKHOFF RD EVANSVILLE, IN 47712				
WEST RIVER HEALTH CAMPUS				EVANS	VILLE, IN 47712		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  BEGLIL ATORY OR LIST DEPICTE VINC INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG			] 1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		+	TAG	DEFICIENCE)		DATE
	12/19/11.						
	0.7040						
		5 P.M., during interview					
		indicated she was the					
	nurse who perfor						
		esident G on 11/21/11.					
		I she "really didn't					
	· ·	indicated the area she					
		rasion on the left hip was					
	"probably redder						
		N # 2 indicated she did					
	not think it would	d have been a pressure					
	area.						
	3. On 5/4/12 at 1						
	Administrator pr	ovided the current					
	facility policy on	"Pressure/Stasis Wound					
	Condition Repor	t Guidelines," undated.					
	The policy include	ded: "Initiate the form					
	when an area of	impairment, (e.g. skin					
	tear, rashabrasi	ion) is identified. 3.					
	Complete the sec	ction titled 'Initial					
	Identification' in	its entirety5. Document					
	description of wo	ound6. Document					
	objective inform	ation about pain"					
	At that same time	e, the Administrator					
	provided the curr	rent facility policy on					
	"Weekly Skin Assessment Guideline,"						
	revised 4/08. Th	e policy included:					
		able Wound Form if a					
		airment is identified"					
	•						
	This federal tag	relates to Complaint					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/21/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER:  155785	A. BUILDING  B. WING	00	COMPLETED 05/04/2012			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
WEST RIVER HEALTH CAMPUS			714 S EICKHOFF RD EVANSVILLE, IN 47712					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	IN00107337.							
	3.1-50(a)(1) 3.1-50(a)(2)							

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